ASSISTED LIVING WAIVER PILOT PROJECT

Care Coordination Provider Eligibility Criteria

Eligibility Criteria

- Agencies must have 5 years experience providing care coordination, which includes the following activities: conducting assessments, developing care plans, arranging and monitoring services, maintaining progress notes and case records, and conducting quality assurance reviews.
- Agencies must have R.N. and Social Services Care Coordinators on staff.
- R.N. Care Coordinators must have and maintain a current, unsuspended, un-revoked license to practice as an R.N. in CA and have work experience that includes either a minimum of 1000 hours in an acute care hospital or a minimum of 2000 hours of experience in a home setting.
- Social Services Care Coordinators must have a bachelor or masters degree in social work, psychology, counseling rehabilitation gerontology or sociology plus one year of related work experience.
- Agencies must enroll as a Medi-Cal Assisted Living Waiver provider.
- Agencies must have mandatory in-service training programs for their staff.
- Agencies must have a process for soliciting and/or obtaining feedback from clients regarding their satisfaction with services.
- Agencies must have a quality assurance program to track:
    - Client complaints
    - Incident reports
- Agencies must maintain a service record for each client. At a minimum, the record must contain all required forms, completed assessments, signed care plans (ISPs), and progress notes. Agencies must agree to make these records available to DHS for audit.
- Agencies must have contingency plans to deliver services in the event of a disaster or emergency.
- Staff must agree to collect data as specified.

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Care Coordination Services

Services Provided by Agency Staff

- Conduct assessments and reassessments using the ALWPP Assessment Tool;
- Develop Individualized Service Plans (ISPs) using the ALWPP ISP Form;
- Submit paperwork to DHS to enroll clients;
- Arrange for the Assisted Living Waiver, Medi-Cal State Plan, and other services determined as necessary by the Assessment Tool and listed on the ISP;
- Monitor provision of services and the ongoing status of participants;
- Maintain progress notes and case records for each enrolled client;
- Adhere to the prescribed schedule of client contact;
- Help transition clients from nursing facilities to RCFEs or public housing;
- Receive complaints from clients, families or friends and forward complaints to DHS;
- Report all signs of abuse or neglect to the Ombudsman or APS; and
- Arrange for payment for vendors as necessary.